

6283

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Ann</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u> 17X224	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>none</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Francis</u> Last <u>Boyles</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-4-1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown William Boyles</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Mary A Mc Natt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown NO</u>	
17. INFORMANT <u>Records Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis.</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>5-10 Min.</u> <u>1 yr. plus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH, <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>23 June '57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centerville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Barton Jr. of Barton Bros. Centerville, Md.</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>  </u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

INVESTIGATION OF DEATH - MEDICAL  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page 1 of 2

1. Name of Deceased: *John A. Smith*

BUREAU V. 3

JUL 1 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06259

Reg. Dist. No.

6284

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>				c. LENGTH OF STAY IN IB <b>1 1/2 Months</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nettie May Brumbley</b>				4. DATE OF DEATH Month Day Year <b>June 23 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1888</b>	
9. AGE (In years last birthday) <b>68 1/2 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Md (Rural)</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel Glasgow</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Layfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Records, Eastern Shore State Hospital and</b>				Address <b>Fruitland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>two days</b> <b>two yrs plus</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rt. Hip Fracture, prior to admission to BSS Hosp. on 5-12-57</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>9040</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dec. slipped and fell, about a week prior to admission.</b>			
20c. TIME OF INJURY Month, Day, Year <b>? Hour a. m. 5/5/57 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				20f. (City or town) (County) (State) <b>Fruitland, Wicomico, Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Eldridge H. Wolff, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>23, June, '57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/26/57</b>			
22c. NAME OF CEMETERY OR CREMATOR <b>St Johns Cem.</b>				22d. LOCATION (City, town, or county) (State) <b>Fruitland, Wicomico, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Co., Salisbury, Md.</b>				24. REC'D BY REGISTRAR <b>6/25/57</b>			
24b. REGISTRAR'S SIGNATURE <b>John H. Hays</b>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY

BUREAU V. S.

JUN 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 20b Film 210 6-17-57 and

6263

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b>		d. STREET ADDRESS <b>R.F.D. #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Died on way to hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cheryl</b> Middle <b>Germaine</b> Last <b>Cephas</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1955</b>		9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b>9</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clemon W Cephas</b>				14. MOTHER'S MAIDEN NAME <b>Ida Marie Jackson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Ida M. Cephas, R.F.D. #1, Vienna, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Injury</b> <b>812X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Fractures of Skull</b> DUE TO (c) <b>Instant</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Run over by auto</b>					
20c. TIME OF INJURY Month, Day, Year <b>11</b> Hour <b>04</b> a.m. <b>6/9/57</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Bucktown Dorchester Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				DATE SIGNED <b>6/11/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bucktown Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dorchester Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter M. St. Clair Jr.</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>John Mace Jr.</b>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION



STATE OF NEW YORK - ALBANY  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUN 17 1957

RECEIVED

*James M. M. M.*

6285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shurlock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shurlock</u>	
c. LENGTH OF STAY IN 1b <u>all life</u>		d. STREET ADDRESS <u>1 Main</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susan Elizabeth Collins</u>		4. DATE OF DEATH <u>4/22</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/1872</u>
9. AGE (In years last birthday) <u>85</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schols</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lillard Collins</u>		14. MOTHER'S MAIDEN NAME <u>Chia Rebecca Andrew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u>	
17. ADDRESS <u>Ms Mrs Thompson, Shurlock</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Cerebral Atrophy</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral atrophy</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0 Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10, 1953</u> , to <u>June 22, 1957</u> , that I last saw the deceased alive on <u>6/15, 1957</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lucy Blum</u> M.D. <u>Preston Maryland</u>		DATE SIGNED <u>6/26/57</u>	
PHYSICIAN'S NAME (Type) <u>Harold B. Plummer</u>		<u>Preston Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/25/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Shurlock, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Keith S. Millonby</u>		24. REGISTRAR'S SIGNATURE <u>John M. M. M.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06262

6286

## CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u> 22 x 22			
c. LENGTH OF STAY IN 1b <u>4yr. 7mo. 11das.</u>				d. STREET ADDRESS —			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>P/</u> Last <u>Daugherty</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>White washer</u>				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Frank Daugherty</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Hearn</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. —				17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hemiparesis, left</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>several yrs.</u> <u>several yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>471X Cerebral arteriosclerosis with psychosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Nov. 5</u> , 19 <u>52</u> , to <u>June 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>57</u> , and that death occurred at <u>11:55PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>Simon Virkutis</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Simon Virkutis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mardela,</u>	
22d. LOCATION (City, town, or county) <u>Mardela Springs, Md.</u>				22e. (State) <u>  </u>		22f. (County) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Marmel-Shayton</u>				ADDRESS <u>  </u>		24. REC'D BY REGISTRAR DATE <u>JUN 19 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>John Mac...</u>				24c. (State) <u>  </u>			

# CERTIFICATE OF DEATH

BUREAU V. 3

JUN 19 1957

RECEIVED

06263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Jorchester		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. POLINE	
Rural Cambridge		1 month		Maryland Caroline	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Eastern Shore State Hospital					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH Month Day Year	
WARREN EDWARD DENISE				June 26 19 57	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
male	white		4/4/77	80 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
electrical		Construction		New Jersey	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Jay Edward Denise		Elizabeth Dixon		U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address	
no		095-07-8046		Eastern Shore State Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 480.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis 304X					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. kl p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21, 1957, to June 26, 1957, that I last saw the deceased alive on June 25, 1957, and that death occurred at 8:50 AM, from the causes and on the date stated above.					
ACTUAL SIGNATURE Thomas J. Dredge M.D.		ADDRESS (Street, city or town, state) DATE SIGNED State Hosp. Cambridge Md 6-26-			
PHYSICIAN'S NAME (Type) Thomas J. Dredge					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial	July 1, 1957	Hill Crest Cemetery		Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
J J Frompton Son Federalsburg Md.		DATE 6/28/57		J J Frompton	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. P.

JUL 1 1957

RECEIVED

6270

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md Hospital</u>		d. STREET ADDRESS <u>5 Fairmount Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elliott</u> Last <u>Elliott</u>		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1898</u>
9 AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-0256</u>	
17. INFORMANT <u>Benny Elliott, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4.24.3</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>June 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>57</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>6-17-57</u>			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		M.D. <u>227 Pine St-Cambridge, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/20/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Taylor's Island</u>	22d. LOCATION (City, town, or county) (State) <u>Taylor's Island, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edwin Fassett</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>J. Edwin Fassett</u>		24b. REGISTRAR'S SIGNATURE <u>J. Edwin Fassett</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUN 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6288

CERTIFICATE OF DEATH

06265

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>310 Cove St.</u>			
3. NAME OF DECEASED (Type or print) First <u>CAREY</u> Middle <u>WELDON</u> Last <u>EVANS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/73</u>	9. AGE (In years lost, birthday) <u>83</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Seaford</u>		11. BIRTHPLACE (State or foreign country) <u>Id.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Horace Evans</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Catherine Marsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give year or dates of service) <u>Sp. American</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Eastern Shore State hospital records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						(b) DUE TO	
						(c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Senile atherosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 7.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>57</u> , to <u>June 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>57</u> , and that death occurred at <u>10:30AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. E.S.S.H., Cambridge, Md.						DATE SIGNED <u>6/6/57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 8/1957</u>		<u>American Legion Cemetery</u>		<u>Crisfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Harvey Bradshaw</u>				24a. REC'D BY REGISTRAR <u>John</u>		24b. REGISTRAR'S SIGNATURE <u>John</u>	

BUREAU V. S.

JUN 12 1957

RECEIVED

6271

Item 9

CERTIFICATE OF DEATH

06267

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gay &amp; Spring Streets</b>		d. STREET ADDRESS <b>Gay &amp; Spring Streets</b>	
3 NAME OF DECEASED (Type or print) First <b>Reginald</b> Middle <b>LeCompte</b> Last <b>Henry</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1957</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1888</b>
9. AGE (In years last birthday) <b>68</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Antique Furniture Repairman Self employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Hampton Henry</b> <b>Octavia LeCompte</b>		14 MOTHER'S MAIDEN NAME <b>Octavia LeCompte</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. <b>No</b>	
17 INFORMANT <b>Mrs. Margaret S. Henry, Gay &amp; Spring St., Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Starvation</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Toxic psychosis sec to metastases of</b> DUE TO (c) <b>Primary Carcinoma of Lt Lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>2 mos</b> <b>?</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Alcoholism Chronic rule Manager's Position</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> to <b>June 9, 1957</b> that I last saw the deceased alive on <b>June 9, 1957</b> and that death occurred at <b>7:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED <b>June 9/57</b>			
ACTUAL SIGNATURE <b>James H. Thompson</b> M.D.		PHYSICIAN'S NAME (Type) <b>James H. Thompson</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thompson</b> ADDRESS <b>Cambridge, Md.</b>		24a REC'D BY REGISTRAR DATE <b>6/12/57</b> 24b REGISTRAR'S SIGNATURE <b>John Macetti</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 17 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06268

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>4yr.9mo.21das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>302 Naylor St.</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edgar</b> Last <b>Hilghman</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-3-96</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland (Fruitland)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore Hilghman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Watson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Disch'g. 6-6-19 -</b>		17. INFORMANT <b>Mrs. Dorothy P. Hilghman (Wife) Naylor St. Sal. Md.</b> <b>RECORDS - Eastern Shore State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John Pace Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Pace Jr.</b>				DATE SIGNED <b>6/17/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun. 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cometary</b>		22d. LOCATION (City, town, or county) (State) <b>R.D. 4 Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>				24a. REC'D BY REGISTRAR <b>DATE 6/20/57</b>		24b. REGISTRAR'S SIGNATURE <b>John Pace Jr.</b>	

BUREAU V. S.

JUN 1 1957

RECEIVED

6290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Rural - Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>William</u> Middle <u>Hubbard</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1888</u>
9. AGE (In years, last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Samuel Edward Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rebecca Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. M. L. Jones</u>		Address <u>RFD 3 Cambridge Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardiovascular Disease</u> DUE TO (c) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 5, 1957</u> to <u>June 6, 1957</u> , that I last saw the deceased alive on <u>June 6, 1957</u> , and that death occurred at <u>2:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ettore De Filippis</u> M.D.		DATE SIGNED <u>June 6, 1957</u>	
PRINTED NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/8/57</u>	<u>Dail Family</u>	<u>RFD # 3, Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u> <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/11/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>J. M. Jones</u>	

RECEIVED

JUN 11 1957

BUREAU V. S.

6291

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before address on) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Graysville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Graysville</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Paul</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1879</u>	9. AGE (in years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Joseph A. Jones</u>		Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>							
DUE TO (b) <u>Chronic Cardiovascular Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. 7</u> Month <u>June</u> Day <u>5</u> Year <u>1957</u> p. m. <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 5, 1957</u> to <u>June 6, 1957</u> , that I last saw the deceased alive on <u>June 6, 1957</u> , and that death occurred at <u>5:30 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ettore De Filippis</u>				ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital</u>			
M.D. <u>Eastern Shore State Hospital</u>				DATE SIGNED <u>June 13 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gracesville</u>		22d. LOCATION (City, town, or county) (State) <u>Gracesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. LANE</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>John T. H. Jr.</u>	
24b. REGISTRAR'S SIGNATURE							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6272

## CERTIFICATE OF DEATH

06272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
c. LENGTH OF STAY in b <b>Life</b>				d. STREET ADDRESS <b>27 Charles Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>27 Charles Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jones</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 15, 1891</b>	
9. AGE (In years last birthday) <b>65</b> yrs		IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stephen Young</b>				14. MOTHER'S MAIDEN NAME <b>Emma Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Eli Young, Cambridge, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I attended the deceased from <b>June 3, 1957</b> , to <b>June 5, 1957</b> , that I last saw the deceased alive on <b>June 5, 1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>227 Pine St-Cambridge, Md.</b> DATE SIGNED <b>6-7-57</b>							
ACTUAL SIGNATURE <b>J. Edwin Fassett</b>				M.D. <b>227 Pine St-Cambridge, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/9/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salem, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard M. Safford</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6/10/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. Edgar Moore, Jr.</b>			

RECEIVED

JUN 11 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6292

## CERTIFICATE OF DEATH

Reg. Dist. No. 07407

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Keene</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1886</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Opher</b>		14. MOTHER'S MAIDEN NAME <b>Annie Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-0716</b>	
17. INFORMANT <b>William L. Keene, Smithsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Starvation &amp; Malnutrition</b> <b>4:20</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senile psychosis</b> DUE TO (c) <b>Anterior basilar ganglia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>32 hrs</b> <b>151</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>304X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 20, 1957</b> to <b>June 23, 1957</b> , that I last saw the deceased alive on <b>June 20, 1957</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>James L. Thompson</b> M.D. <b>June 23, 1957</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/26/1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert H. St. John</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR <b>7/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>John Mace</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 19 1957

RECEIVED

6293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POWELLVILLE</u> (Powellville)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>R.D. # 1 Pittsville</u>	
3. NAME OF DECEASED (Type or print) First <u>ADDIE</u> Middle <u>MAE</u> Last <u>KELLEY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 22 1894</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> Hours <u>18</u> Min <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State of foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>JOHN HENRY PARKER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISIANA Adkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS</u>	
17. INFORMATION <u>ESSH</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEMI PLEGIA</u> DUE TO (c) <u>DIABETES MELLITUS</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC CEREBRAL ARTERIOSCLEROSIS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 11</u> , 19 <u>57</u> , to <u>JUNE 18</u> , 19 <u>57</u> that I last saw the deceased alive on <u>JUNE 18</u> , 19 <u>57</u> , and that death occurred at <u>1:50 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>ESSH - Cambridge, Md.</u> DATE SIGNED <u>JUNE 18 1957</u>			
ACTUAL SIGNATURE <u>Harry J. Crawford</u> M.D.		PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jun. 21, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Perdue Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Powellville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>6/20/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John Maca...</u>			

RECEIVED

JUN 24 1957

BUREAU V. S.

6294

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Since 3-20-54</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Williamsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lilly</u> Middle <u>White</u> Last <u>Jelly</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-82</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William White</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Cockle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson Son Federalburg Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

MEDICAL CERTIFICATION

1. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

2. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

JUN 1900

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN lb <u>16 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crapo Md.</u>		d. STREET ADDRESS <u>Crapo Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Elizabeth</u> Last <u>Kirwan</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18.</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>	IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Crapo Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Webster</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Ogle Bradford Crapo Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>40</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intratrochanteric fracture r. femur</u> DUE TO (c) <u>    </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>16 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>    </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Leg "gave way" as she walked to auto.</u>					
20c. TIME OF INJURY Month, Day, Year <u>6-2-1957</u> Hour <u>    </u> P. M. <u>    </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nr. Home</u>		20f. (City or town) (County) (State) <u>Crapo Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service Cambridge Md.</u>				24a. REC'D BY REGISTRAR <u>6/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

DATE SIGNED

6/19/57

RECEIVED

JUN 24 1957

BUREAU V. S.

6295

## CERTIFICATE OF DEATH

Reg. Dist. No.

06270

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1/2 rural Williamsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fisher Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hattie Hubbert Lord</b>		4. DATE OF DEATH Month Day Year <b>June 22, 1957 19</b>	
5. SEX <b>fem.</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1979</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Hubbert</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Gambrill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Miss Madeline Lord Williamsburg, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Dehydration due to Enteritis - non specific</b> <b>172.5</b> DUE TO <b>Chronic Colitis + Diverticulitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 yr 2 +</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility; Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>June 22, 1957</b> , that I last saw the deceased alive on <b>June 21, 1957</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hurlock, Md.</b> DATE SIGNED <b>6/23/57</b>			
ACTUAL SIGNATURE <b>W.C. Harrison</b> M.D.		PHYSICIAN'S NAME (Type) <b>W.C. Harrison MD</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 26, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Williams</b>		ADDRESS <b>Federalsburg, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>June 26, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Chas. Hastings</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 1 1957

BUREAU V. S.

6296

## CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>23 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				e. STREET ADDRESS <u>824 Brown St.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Washington</u> Last <u>McNelia</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1870</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benny McNelia</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>217-12-4886</u>		17. INFORMANT <u>EASTERN SHORE STATE HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Senile Brain Syndrome</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Senile Brain Disease, W.Psy.Reac.</u>							19. WAS AUTOPSY PERFORMED? • YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>6/4/57</u> , 19 <u>  </u> , to <u>6/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/27</u> , 19 <u>57</u> , and that death occurred at <u>12:15AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin J. Ward</u>		M.D. <u>Eastern Shore State Hosp.</u>		ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u>		DATE SIGNED <u>6-27-57</u>	
PHYSICIAN'S NAME (Type) <u>Edwin J. Ward, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smith Mills</u>		22d. LOCATION (City, town, or county) <u>Delmar, Del.</u>		(State)	
23. FLANERAT DIRECTOR'S SIGNATURE <u>H. S. Hornell Co. Delmar, Del.</u>		ADDRESS <u>Delmar, Del.</u>		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1 1 1957

RECEIVED

6274

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>Md.</b>		b. COUNTY <b>Dorchester Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>		c. LENGTH OF STAY IN lb <b>1 Week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toddsville Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Md. Hospital</b>		d. STREET ADDRESS <b>Toddsville Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lewis</b>		First <b>W.</b>		Middle <b>Meredith</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Jan. 31, 1872</b>		9. AGE (in years last birthday) <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>		11. BIRTHPLACE (State or foreign country) <b>Toddsville Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mrs Eldridge Smith</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Primary Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 14, 1957</b> to <b>6/21, 1957</b> , that I last saw the deceased alive on <b>June 21, 1957</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>104 Locust St. Cambridge Md.</b>		DATE SIGNED <b>6/21/57</b>	
ACTUAL SIGNATURE <b>W. H. Hanks</b>		PHYSICIAN'S NAME (Type) <b>W. H. Hanks</b>		DATE <b>6/24/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem Park</b>	
22d. LOCATION (City, town, or county) <b>Cambridge Md.</b>		22e. REC'D BY REGISTRAR <b>John Moore</b>		22f. REGISTRAR'S SIGNATURE <b>John Moore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		ADDRESS <b>Cambridge Md.</b>		DATE <b>6/24/57</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55



BUREAU V. S.

JUN 27 1937

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06279

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Worcester</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>5 mos. 19 das.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Worcester</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u> d. STREET ADDRESS <u>---</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Merritt</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>4</u> Year <u>1957</u>					
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-28-80</u>			
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>---</u> Days <u>---</u>		<b>IF UNDER 24 HRS.</b> Hours <u>---</u> Min. <u>---</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>House</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <u>Stockton</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Thomas Merritt</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Susan - Mankall</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Eastern Shore State Hospital records</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <table style="width: 100%;"> <tr> <td style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Massive pulmonary embolus</u>  <u>902.7</u> <b>DUE TO</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b)</b> <u>Generalized arteriosclerosis</u>  <b>DUE TO</b>  <b>(c)</b> <u>Intertrochanteric fracture of right hip</u> </td> <td style="width: 20%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>10 min.</u>  <u>5 yr. plus</u>  <u>5-20-57</u> </td> </tr> </table> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Ch. Fr. Sy. Assoc. With Cerebral Arteriosclerosis With Psychotic Reaction</u>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Massive pulmonary embolus</u> <u>902.7</u> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <u>Generalized arteriosclerosis</u> <b>DUE TO</b> <b>(c)</b> <u>Intertrochanteric fracture of right hip</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 min.</u> <u>5 yr. plus</u> <u>5-20-57</u>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Massive pulmonary embolus</u> <u>902.7</u> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <u>Generalized arteriosclerosis</u> <b>DUE TO</b> <b>(c)</b> <u>Intertrochanteric fracture of right hip</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 min.</u> <u>5 yr. plus</u> <u>5-20-57</u>						
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell while trying to get out of chair</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>7:30</u> a.m. <u>5-30</u> 19 <u>57</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Eastern Shore State Hospital</u>			
<b>20f. CITY OR TOWN</b> (County) (State) <u>Cambridge, Worcester, Md.</u>		<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>Eldridge H. Wolff</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>Eldridge H. Wolff</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>6-4-57</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>June 7/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Chesapeake</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Stockton</u> <u>Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. E. Lewis</u> <b>ADDRESS</b> <u>Stockton, Md.</u>					
<b>24a. RECEIVED BY REGISTRAR</b> <u>June 6 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. P. Mason, Jr.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 6 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06280

6298

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Orchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WALLACE</b> <b>Ivan</b> <b>MILLIKEN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/97</b>	9. AGE (in years last birthday) <b>59</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.Y. Linwood New York, N.Y.</b>	
13. FATHER'S NAME <b>J. David Milliken (James D. Milliken)</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Angelica Miinte.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Eastern Shore State Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>440.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Deficiency without psychosis</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11</b> , 19 <b>52</b> , to <b>June 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 11</b> , 19 <b>57</b> , and that death occurred at <b>6 a.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D. <b>Eastern Shore State Hospital, Cambridge, Md.</b> <b>6/11/57</b>				PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13, 57.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mardela, Cemetery.</b>		22d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Co.</b>				ADDRESS <b>Salisbury, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>6/15/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. R. Mace Jr.</b>			

RECEIVED

JUN 17 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6275

06281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge Md.</b>			c. LENGTH OF STAY IN 1b <b>Life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3 Cambridge Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Home Cambridge Md.</b>				d. STREET ADDRESS <b>Cambridge Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah F.</b> Middle <b>Moore</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>April 8, 1871</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Neck Dist. Dorchester Co. USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Nemiah Beckwith</b>			
14. MOTHER'S MAIDEN NAME <b>Frances Mitchell</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Willard Moore Cambridge RFD # 3 Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1X</b> DUE TO (c) <b>10 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John Mace Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>6/12/57</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>June 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge Md.</b>	
24a. REC'D BY REGISTRAR <b>6/12/57</b>				24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>			

BUREAU V. S.

JUN 17 1957

RECEIVED

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6299

## CERTIFICATE OF DEATH

06282/16

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 1 mo. 21 das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>Rt. 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wesley</b> Last <b>Nichols</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-18-83</b>	9. AGE (In years last birthday) <b>73</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alex. Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Murphy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Eastern Shore State Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic cardiovascular disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-5</b> , 19 <b>57</b> , to <b>6-6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-6</b> , 19 <b>57</b> , and that death occurred at <b>8:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Ettore DeFilippis</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Ettore DeFilippis</b>				<b>S.S.S. Hospital, Cambridge, Maryland 6-6-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 9, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Federalburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Williamson</b>				ADDRESS <b>Federalburg, Md.</b>		24a. REC'D BY REGISTRAR <b>6/3/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ernest H. Smith, Jr.</b>			



BUREAU V. S.

M 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06284

6300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>29 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>			d. STREET ADDRESS <b>-</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>-</b> Last <b>Payne</b>			4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1957</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-23-82</b>		9. AGE (In years last birthday) yrs. <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Isaac Payne</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ann Dueberry</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4543</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Cardiac Disease</b> DUE TO (c) <b>General Arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> Month <b>June</b> Day <b>19</b> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
			20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 11</b> , 19 <b>57</b> , to <b>June 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 12</b> , 19 <b>57</b> , and that death occurred at <b>10:30 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Ettore De Filippis</b> M.D. <b>E.S.S. Hospital, Cambridge, Maryland</b> <b>6-12-57</b> PHYSICIAN'S NAME (Type) <b>Dr. Ettore De Filippis</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Henry Pappas</b>			ADDRESS <b>Elkton, Del.</b>		24a. RECEIVED BY REGISTRAR <b>June 17, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>John H. Pappas</b>	

RECEIVED

JUN 17 1957

BUREAU V. S.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6276**  
**CERTIFICATE OF DEATH**

06285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>317 Oakley St.</u>				d. STREET ADDRESS <u>317 Oakley St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Miriam</u> Middle <u>Eugene</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1897</u>	9. AGE (In years last birthday) <u>60 Yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Mowbray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Eliza beth Phillips 317 Oakley St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease -</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Asthma</u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/5/57</u> 19 <u>57</u> , to <u>6/17</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6/17</u> 19 <u>57</u> , and that death occurred at <u>9:00</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawrence Marysnor</u> M.D.				ADDRESS (Street, city or town, state) <u>136 Race St. Cambridge, Md.</u>		DATE SIGNED <u>6/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Lawrence Marysnor MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 19, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/19/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 1 1957

BUREAU V. S.

6301

CERTIFICATE OF DEATH

06286/16

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>sent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>-</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Reese</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1877 ?</u>	
9. AGE (In years last birthday) <u>79 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>19</u> Min <u>57</u>		IF UNDER 24 HRS Months <u>13</u> Days <u>13</u> Hours <u>19</u> Min <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Don't Know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Cardiac Disease</u> DUE TO (c) <u>General Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1134.3</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 17</u> , 19 <u>57</u> , to <u>June 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>57</u> , and that death occurred at <u>8:45</u> p. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital, Cambridge, Maryland</u> DATE SIGNED <u>6-19-57</u>							
ACTUAL SIGNATURE <u>Ettore DeFilippis</u> M.D. <u>E.S.S. Hospital, Cambridge, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Ettore DeFilippis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REG. DIST. BY REGISTRAR <u>21-1957</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Willis Wells</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST PAUL V. S.

NOV 14 1967

RECEIVED

6277

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X. RFD # 3, Cambridge, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Russell</b> Middle <b>V.</b> Last <b>Ryder</b>				4. DATE OF DEATH Month <b>6</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/11/1885</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public transportation</b>		11. BIRTHPLACE (State or foreign country) <b>Owls Head, Maine</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Not known</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Not known</b>		17. INFORMANT <b>Edward Mitchell, RFD # 3, Cambridge, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/27</b> , 19 <b>57</b> , to <b>6/28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/25</b> , 19 <b>57</b> , and that death occurred at <b>10:45</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.				ADDRESS (Street, city or town, state) <b>136 Race St</b>			
PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>				DATE SIGNED <b>Cambridge, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Wollaston Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quincy, Mass.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>7/1/57</b>		24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUL 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6278

CERTIFICATE OF DEATH

Reg. Dist. No. 06288

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emerson</u> Middle <u>Seward</u> Last <u>Seward</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>65</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Neck Dist. Dorchester Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Seward</u>				14. MOTHER'S MAIDEN NAME <u>Ella Todd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Dale Suffler</u> Address <u>Cambridge Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>dissect</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-13-55</u> 19 <u>55</u> , to <u>6-25</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6-25</u> 19 <u>57</u> , and that death occurred at <u>12:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge</u> DATE SIGNED <u>Jul 6-28-57</u>							
ACTUAL SIGNATURE <u>W. Bannerman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Cambridge</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Speddens - Seward</u>		22d. LOCATION (City, town, or county) (State) <u>James Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/1/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Macoy</u>			

BUREAU V. S.

JUL 1957

RECEIVED  
JUL 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6302

## CERTIFICATE OF DEATH

06289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>			c. LENGTH OF STAY IN 1b <b>1 months</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>SPEAR</b> Last <b>SPEAR</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7/8/13</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>28</b>	IF UNDER 24 HRS Hours <b>8</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waterman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>waterman</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John Spear</b>				14. MOTHER'S MAIDEN NAME <b>Mary Thompson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Eastern Shore State Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Psychosis</b>							19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Feb 5</b> , 19 <b>54</b> , to <b>June 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 6</b> , 19 <b>57</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D. <b>E.S.S. Hospital, Cambridge, Md.</b> <b>6/6/57</b>							
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 8 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harlock</b>		22d. LOCATION (City, town, or county) (State) <b>Harlock Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. B. McLaughlin</b>				24a. REC'D BY REGISTRAR <b>H. B. McLaughlin</b>		24b. REGISTRAR'S SIGNATURE <b>H. B. McLaughlin</b>	

BUREAU V. 8

JUN 17 1957

RECEIVED

## CERTIFICATE OF DEATH

07422

Reg. Dist. No.

6279

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 Fairmount Ave.</b>				d. STREET ADDRESS <b>7 Fairmount Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Preston</b> Middle <b>Stanley</b> Last <b>Stanley</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 3, 1898</b>	
9. AGE (In years last birthday) <b>58</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Packing</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-9863</b>		17. INFORMANT <b>Amelia Stanley, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis, acute</b> 4-1 DUE TO <b>Arterio-sclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Hypertension CVD</b> DUE TO (b) <b>?</b> (c) <b>Colostomy</b>				INTERVAL BETWEEN ONSET AND DEATH <b>June 23, 57</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24-12X</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 20</b> , 19 <b>57</b> , to <b>June 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 20</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b> DATE SIGNED <b>June 23, 1957</b>							
ACTUAL SIGNATURE <b>A. Thomas Pearson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>A. Thomas Pearson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/27/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithsville Ceme.</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter H. H. H. H.</b> ADDRESS <b>Cambridge, Md.</b>				24a. REC'D BY REGISTRAR <b>7/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 10 1957

BUREAU V. S.

## CERTIFICATE OF DEATH

VS A15 (4)  
15M 9/55



RECEIVED

JUN 1 1957

BUREAU V. S.

6280

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
c. LENGTH OF STAY IN lb <b>8 yrs.</b>				d. STREET ADDRESS <b>Cross Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Md. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Doris</b> Middle <b>Shirley</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1929</b>	
9. AGE (In years last birthday) <b>28</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Packing</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Collins Banks</b>			
14. MOTHER'S MAIDEN NAME <b>Maryha Stanley</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Martha Stanley Banks, Cambridge, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>6/19, 1957</b> to <b>6/20, 1957</b> that I last saw the deceased alive on <b>6/20, 1957</b> , and that death occurred at <b>12:55 A.M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.				ADDRESS (Street, city or town, state) <b>136 Race St. Cambridge, Md</b>			
DATE SIGNED <b>6/24/57</b>							
PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trappe Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Trappe, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. [Signature]</b> ADDRESS <b>Cambridge, Md.</b>				24a. REC'D BY REGISTRAR <b>7/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>Jake Macg...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JUL 10 1957

RECEIVED



RECEIVED

1 1957

BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6305

Items 10a, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

## CERTIFICATE OF DEATH

06293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>8 Mos 6 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>514 Race St</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Vincent</u> Last <u>Vincent</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3 1900</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dorchester Co., Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Vincent</u>		14. MOTHER'S MAIDEN NAME <u>Laura Vane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records Cambridge Md</u>	
17. INFORMANT <u>Hospital Records Cambridge Md</u>		Address <u>Cambridge Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>450.0</u> DUE TO (c) <u>450.0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. <u>11</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 9</u> , 1956, to <u>June 15</u> , 1957, that I last saw the deceased alive on <u>June 14</u> , 1957, and that death occurred at <u>1240 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas T. Dredge</u> M.D.		ADDRESS (Street, city or town, state) <u>E.S. State Hosp Cambridge</u>	
PHYSICIAN'S NAME (Type) <u>Thomas T. Dredge</u>		DATE SIGNED <u>6-15-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/17/57</u>		22b. DATE THEREOF <u>CAMBRIDGE MD</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CAMBRIDGE MD</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LECOMPTÉ FUNERAL SERVICES</u>		ADDRESS <u>DATE 6/17/57</u>	
24a. REC'D BY REGISTRAR <u>John Macen Jr.</u>		24b. REGISTRAR'S SIGNATURE	

RECEIVED

JUN 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
6306 CERTIFICATE OF DEATH											
Reg. Dist. No. 06294											
1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linkwood</b>			c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linkwood</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Merrick Convalescent Home</b>					d. STREET ADDRESS <b>Rural</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>Joseph William Walling</b>					4. DATE OF DEATH Month Day Year <b>June 26, 1957 19</b>						
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1890</b>		9. AGE (In years last birthday) <b>67 yrs.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13 FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family Records</b>							
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Thrombosis of coronary artery</b>											
DUE TO <b>arteriosclerosis of coronary artery</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO <b>arteriosclerosis of coronary artery</b>											
(c) <b>arteriosclerosis of coronary artery</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Complication of old coronary artery</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>450.1</b>					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>June 27, 1957</b> to <b>June 26, 1957</b> that I last saw the deceased alive on <b>June 22, 1957</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>John Mace Jr.</b>					ADDRESS (Street, city or town, state) <b>Cambridge, Md.</b>						
DATE SIGNED <b>June 1 1957</b>					24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>June 28, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Easton, Maryland</b>		
23 FUNERAL DIRECTOR'S SIGNATURE <b>R. E. Clarke</b>					ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>June 1 1957</b>			24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>	



RECEIVED

MAY 1 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06295

## 6281 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>223 Robbins St.</b>				d. STREET ADDRESS <b>223 Robbins St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lee Ondos Wheatley</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 19, 1897</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Parts Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Wheatley</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Collins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War 1 220-12-1719</b>		17. INFORMANT Address <b>Mrs Lydia R. Wheatley 223 Robbins St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio Sclerosis</b> (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 in.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John M. [Signature]</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John M. [Signature]</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6/15/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 6/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>John M. [Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 17 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6307

CERTIFICATE OF DEATH

06296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 5 das.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Princess Anne</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-87</u>	9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Julia Shores</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-05-8797</u>		17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio-vascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 17</u> , 19 <u>57</u> , to <u>June 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>57</u> , and that death occurred at <u>7:20 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ettore De Filippis</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. E.S.S. Hospital, Cambridge, Md. 6-19-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Ettore De Filippis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>				ADDRESS <u>Princess Anne</u>		24a. REC'D BY REGISTRAR <u>JUN 24 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mace</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 24 1957

BUREAU V. S.

6308

## CERTIFICATE OF DEATH

06297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge RFD # 3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge RFD # 3</u>	
c. LENGTH OF STAY IN IB <u>70 Yrs.</u>		d. STREET ADDRESS <u>Cambridge RFD # 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge RFD # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Irvin</u> Middle <u>Wingate</u> Last <u>Wingate</u>		4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Wingate Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Wingate</u>		14. MOTHER'S MAIDEN NAME <u>Laura Fallin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Alfred Wingate</u>		Address <u>Cambridge RFD # 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio and arteriolar nephrosclerosis</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia, right - 2 months. Carcinoma of prostate - 5 years.</u> <u>177 X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>6 months+</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>
21. I certify that I attended the deceased from <u>July 3, 1942</u> , to <u>June 20, 1957</u> , that I last saw the deceased alive on <u>June 20, 1957</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Locust Street, Cambridge, Md.</u> DATE SIGNED <u>6-26-57</u>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.		DATE SIGNED <u>6-26-57</u>	
PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>		DATE SIGNED <u>6-26-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 27, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		24a. REC'D BY REGISTRAR <u>John Maczyn</u>	
ADDRESS <u>Cambridge Md.</u>		24b. REGISTRAR'S SIGNATURE <u>John Maczyn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

6208

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MA

BUREAU V. 8

JUL 8 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 F11-G218 7-18-57 et

6282

## CERTIFICATE OF DEATH

Reg. Dist. No.

06298

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>51B Douglas St</u>		d. STREET ADDRESS <u>51B Douglas Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Alverta</u> Middle <u>Stewart</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stewart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mary Wingate, Cambridge, Md.</u>	
17. INFORMANT Address <u>Mary Wingate, Cambridge, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>434.3</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>June 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>57</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>6-22-57</u>			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		M.D. <u>J. Edwin Fassett, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/23/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. St. Lawrence</u>		ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>6/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	



CERTIFICATE OF DEATH

BUREAU V. S.

JUN 27 1957

RECEIVED